

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 14 1941

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

2027
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 102
 (b) Township Jackson Primary Registration District No. 4062 Registered No. 44
 (c) City _____ or _____
 (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME James Edward Houchins

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sally Stultz

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 23 1857

7. AGE YEARS 83 MONTHS 0 DAYS 24 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Callaway Co. Mo. (STATE OR COUNTRY)

FATHER 13. NAME James Houchins
 14. BIRTHPLACE (CITY OR TOWN) St. Louis Co. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Martha Clopton
 16. BIRTHPLACE (CITY OR TOWN) Mo. K. (STATE OR COUNTRY)

17. INFORMANT C. H. Houchins (ADDRESS) McMeadow Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cheney DATE June 19 1941

19. FUNERAL DIRECTOR (NAME) Hughes Maupin (ADDRESS) Amvassie Mo.20. FILED Jan 18 1941 E. B. Nichols Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 194122. I HEREBY CERTIFY That I attended deceased from Jan 14 1941 to Jan 17 1941

I last saw him alive on January 17 1941. Death is said to have occurred on the date stated above, at 5740 P.

The principal cause of death and related causes of importance were as follows:

Influenza
 Date of onset

Other contributory causes of importance: 3312

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) E. B. Nichols M. D.
 (Address) Amvassie Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Hughes Maupin
Licensed Embalmer No. 2358
P. O. Address Aux Vasse

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 2027

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 102

Primary Registration District No. 4062

Registrar's No.

1. PLACE OF DEATH:

- (a) County Callaway
(b) City or town Jacksboro
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community. years, months or days)

3. (a) PRINT FULL NAME

- James Edward Houchins
3. (b) If veteran name war. 3. (c) Social Security No.

4. Sex m 5. Color or race ee 6. (a) Single, widowed, married, divorced urd
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 0 24 hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.
13. Birthplace. (City, town, or county) (State or foreign country)
14. Maiden name.
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)
(c) Place: burial or cremation.

18. (a) Signature of funeral director.
(b) Address.

19. (a) Jan 19 41 (b) C. B. Nichols
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Callaway
(c) City or town Arxvass
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

20. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Jan day 17 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from. 19. to. 19. that I last saw him alive on. 19. and that death occurred on the date and hour stated above.
Immediate cause of death.

- Due to.

- Due to.

- Other conditions. (Include pregnancy within 3 months of death)

- Major findings:
Of operations.

- Of autopsy.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? (Specify type of place) (e) Means of injury

23. Signature C. B. Nichols (M. D. or other)
Address Arxvass Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

